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ABSTRACT

A project was implemented which attempted to reduce the number of children from kindergarten through second grade whose counseling services are terminated prematurely, or who receive suboptimal counseling services because their active participation could not be engaged in the evaluation and counseling processes. Seven individual sessions were held with each of four children participating in the program. Using the view-through mode with videocassette recorder (VCR) camera and mointor, children who previously could not be engaged were encouraged to interact with the television on a variety of activities. Evaluative activities involving art, story telling, and play were carried out while interacting with the television. An additional three sessions were held with each child without the use of the VCR equipment. The results of the intervention were encouraging. Participatory behavior for all but one of the children was increased to the point at which they were able to complete all three of the evaluation tasks; the remaining child was able to complete two of the three tasks. Carryover of participatory behavior without the use of the VCR was noted for all of the children. Although none of the children was speaking to anyone in the school at the start of the project, half of the participating children began to speak on a limited basis by the time the project was completed. (Author/ABL)

Using Video Technology to Encourage Reluctant Primary School Children to Participate Actively in the Evaluation and Counseling Processes

by

Daniel J. Russo

Cluster XXXVI

A Practicum I Report Presented to the
Ed.D. Program in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

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PRACTICUM APPROVAL SHEET

This practicum took place as described.

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This practicum report was submitted by Daniel J. Russo under the direction of the adviser listed below. It was submitted to the Ed.D. Program in Early and Middle Childhood and approved in partial fulfillment of the requirements for the Doctor of Education at Nova University.

Approved:

8/31/91
Date of Final Approval of Report

Polly Peterson, Ph.D.
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TABLE OF CONTENTS

LIST OF TABLES

Table

LIST OF FIGURES

Figure

ABSTRACT

Using Video Technology to Encourage Reluctant Primary School Children to Participate Actively in the Evaluation and Counseling Processes. Russo, Daniel J., 1991: Practicum I Report, Nova University, Ed.D. Program in Early and Middle Childhood. Descriptors: Primary Education/Counseling/ Counseling Techniques/Counselor Client Relationship/ Videotape Cassettes/Shyness.

This practicum aimed to reduce the number of children whose counseling services are terminated prematurely, or who receive suboptimal counseling services because their active participation cannot be engaged in the evaluation and counseling processes.

Seven individual sessions were held with each child participating in the program. Using the view-through mode with VCR camera and monitor, children who could not previously be engaged were encouraged to interact with the television on a variety of activities. Evaluative activities involving art, story-telling, and play were carried out while interacting with the television. An additional three sessions were held with each child without use of the VCR equipment.

The results of the practicum were encouraging. Participatory behavior for all but one of the children was increased to the point where they were able to complete all three of the three evaluation tasks; the remaining child completed two of the three tasks. Carryover of participatory behavior without use of the VCR was noted for all of the children. Although none of the children were speaking to anyone at all in school at the start of the project, half of the participating children began to speak in school on a limited basis by the time the project was completed.

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CHAPTER I

INTRODUCTION

Description of Work Setting and Community

This practicum was conducted in a private psychological clinic specializing in school-related issues among children and youth between the ages of four years and nineteen years. Approximately one-third of the clinic's caseload involves the psychoeducational assessment of students with potential needs for special programming. Referral of these clients is generally initiated by parents who wish to avoid the long waiting lists common in the local schools, or who feel distrustful of or antagonistic towards the schools. A second one-third of the clinic's caseload involves diagnosis of attention deficit/hyperactivity disorder, along with related follow-up with children and their parents. Referral of these youngsters generally originates with local pediatricians. A final third of the caseload involves providing counseling or therapy for youngsters with a variety of behavioral and performance problems which affect, among other things, school success. These children are typically referred by school counselors.

The clinic is situated on the main street of a town of approximately 10,000 people located in the mid-Atlantic region. Within the past ten years, the town has changed

from a semi-rural center to a suburban community. Referrals are drawn from an overall population of approximately 300,000 people representing a complex patchwork of four counties, dozens of municipalities, twenty school districts, and many well-used, church related schools which span the religious spectrum. The environment is a mix of small-town, rural, and suburban communities, centering on a single small city which is the state capital. The population is widely varied, ranging from the very wealthy and well-educated, to a distinctly Appalachian culture. Minority populations, outside of the small urban district, however, are markedly under-represented. Clients seen at the clinic come from all groups in the area.

The Writer's Role in the Work Setting

The writer is owner of the clinic and is directly responsible for all aspects involved in running the business and providing professional services. The writer occasionally supervises part-time psychologists and counselors, and is responsible for liaison with school professionals, physicians, and representatives of other agencies in the community. Since ultimate decision-making responsibility rests with the writer, there is a great deal of latitude for initiating and implementing new programs.

Because of this central role of the writer, however, there is very little support available from others.

The writer's educational background includes an M.A. degree in psychology of personality and an M.S.Ed. degree in school psychology. The writer is certified as a school psychologist and is licensed by the state for private practice as a psychologist. Professional experience includes seven years as a special education teacher, eight years as a school psychologist in a district of 9,000 students, and eight years as owner and director of the private psychological clinic.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

When a child is brought to the clinic for counseling because of school-related behavioral or performance problems, a two-phase process is begun. During the first phase, the child must be evaluated in order for the writer to be able to gain descriptive information of the child's difficulties, to form preliminary hypotheses concerning possible causes, and to identify appropriate intervention(s). During the second phase, the emphasis is on providing direct intervention, although assessment remains an ongoing element throughout the psychologist's involvement with the child.

With some children, it is difficult or impossible to establish a productive relationship because the child resists all attempts to be drawn into that relationship. This sometimes happens because the presenting problem is, itself, the inability of the child to interact with others, particularly adults. More often, however, the causes are not readily apparent.

The first phase, assessment, typically consists of non-psychometric, as opposed to psychometric, evaluation. With traditional, psychometric evaluation, the child is generally

placed at a table and required to answer specific questions or to complete rigidly delimited tasks. Within that well-structured setting, virtually all children will respond with some degree of adequacy. During the process of non-psychometric evaluation, however, the child is presented with a variety of relatively open ended tasks (e.g. incomplete sentences, story-telling), or must engage in relatively spontaneous activities, such as drawing or play. In addition, some degree of "interview" is attempted, depending, of course, on the child's level of verbal and conceptual development. The child who finds it exceptionally difficult or impossible to interact with an adult obviously does not perform well, if at all, on these types of tasks. Thus, the practitioner is faced with a choice either of terminating involvement with the child at that point, or of proceeding with the intervention, even though there is little more than second-hand reports from parents and teachers on which to develop a plan, and even though the child remains entirely passive during the counseling sessions.

A second group of children may perform adequately during the assessment stage because of its relative, albeit minimal, structure, but then cease to interact during the second, intervention phase. They join those children who were unsuccessful during the first phase, becoming equally

at risk for premature termination or reduced effectiveness of services.

To deal with the problem of engaging children, a variety of approaches has been proposed. These generally include variations of play activities, drawing activities, and story-telling activities. Unfortunately, these techniques are not always sufficient to overcome the child's initial reserve, and may also fail to produce a carryover effect, resulting in total dependence on that particular technique.

Thus, the problem was that, (A) because some children cannot or will not interact adequately with the professional, either verbally or nonverbally, assessment and/or counseling services are often terminated prematurely, and (B) if services are indeed continued with such children, they are often provided within a distinctly suboptimal context.

Problem Documentation

A review of 362 children referred to the clinic for counseling due to school-related problems during the years 1986-1990, inclusive, showed that 55 were considered "significantly difficult to engage." Of these, 26 were discharged prematurely because they could not be adequately engaged in the assessment process. Although work continued

for several months with the remaining 19 children, intervention was considered successful with only three of these. Moreover, of the original 55 children who were difficult to engage, the majority were perceived as demonstrating seriously dysfunctional school-related behaviors. Thus, while approximately 7% of the total referred population was considered difficult to engage, the incidence of serious problems within that group was high. The impression is therefore given that it is those children who may need intervention the most who often end up being discharged prematurely.

Recent informal interviews with eight elementary guidance counselors and eight psychologists indicated that all were confronted with this problem at present, and that they had experienced this problem throughout their professional careers. All persons interviewed stated that they currently had at least one child on their caseload who could not be engaged.

Within the broader professional community, techniques for dealing with this problem were specifically and extensively addressed in a well-attended workshop presented by pediatric psychiatrist Richard Gardner in 1985.

In addition to counselors and psychologists, virtually every teacher with whom the writer consulted had expressed concern over a child who could not be engaged. Thus, while

the problem appeared in the writer's specific current work setting, it also had manifested itself in another, closely related arena. It was, therefore, possible that a solution which was found to be effective within the writer's work setting might be of value in the school setting as well.

Causative Analysis

Causes of the problem are potentially as numerous and varied as are the existing schools and sub-schools of counseling theory and human behavior. In general, the focus has been on the internal dynamics of the child. Within the context of the present practicum, however, focus was shifted to the actual encounter of adult and child. Viewed from this perspective, there appeared to be four specific causes which were operating.

First, there has been the general assumption that play, art, and story-telling techniques involve essentially spontaneous activities which the child directs. In actuality, these activities, while relatively loosely structured, nevertheless require a child to do something as specifically directed and defined by an adult, within rather narrow limits set by the adult, and under the watchful eye of the adult. Thus, the counseling encounter merely replicates the child's outside experiences with adults and

authority, even though success in that area has already been minimal for the child.

Second, it would seem that the commonly prescribed approaches to engagement involve activities with which the child is already over-familiar. As such, these activities may have insufficient novelty to overcome shyness and/or resistance.

Third, the conventional activities may already carry an association of failure for the child, based on such personal history as poor artistic ability, poor motor skills, poor expressive skills, or lack of success in playing with peers.

Fourth, the shy or excessively inhibited child, when asked to draw, act, play, or tell stories in the unfamiliar setting of the consulting room, has no way of monitoring his or her own behavior. Fearful of doing the "wrong" thing, or of appearing foolish, the child may opt to do little or nothing.

Relationship of the Problem to the Literature

The challenge of enabling reluctant children to actively participate in the counseling process, or in the type of non-psychometric testing which typically precedes and accompanies such counsel ng, is widely recognized as problematic by counselors and psychologists in the field. While this problem is recognized in the literature as well,

very little work appears to have been done which directly addresses the problem. Thus, recognition primarily occurs obliquely within other studies and articles which are designed primarily to advance a particular technique for doing therapy with children.

In what is apparently the only significant study which has directly addressed this problem (Taylor, Adelman, & Kaser-Boyd, 1985), 42 children between the ages of 10 and 19 were assessed; all of these children had been referred for counseling due to learning problems and attendant behavioral/emotional problems. Within this group, 79% showed some degree of reluctance to become engaged in the counseling process, as evidenced by simple refusal to participate, expressions of ambivalence, avoidance, and premature termination. No attempt was made in the study, however, to classify children according to the degree of reluctance shown.

In examining the dynamics of the observed reluctance, the authors found that the children tended to blame negative attributes of the counseling situation itself for their resistance, and that they resented the fact that they had not been involved in the decision to begin counseling. Lack of motivation (not clearly defined) was also cited as a factor. On the other hand, counselors and parents tended to blame negative attributes of the children, such as

rebelliousness or defensiveness, for the resistance. The results of a one-year follow-up of 25 of the children revealed a high degree of consistency in their attitudes towards the counseling, suggesting that efforts to overcome the resistance had been largely ineffective. The study, however, did not focus on specific techniques.

In a smaller, and less directly relevant study, Bow (1988) reported on five children, between the ages of 5 and 16 years, who could not initially be successfully engaged in the counseling process. The factors presumed responsible for the children's reluctance included lack of understanding about what is taking place, perceived threats to autonomy, and, again, lack of motivation. Of the four factors discussed as important in engaging these reluctant children, three of them (the counselor's personality, making initial contact, and establishing a relationship) are too broad to be useful and they clearly beg the issue. The fourth factor (use of play therapy) brings the reader to the true purpose of the article, which is to encourage the use of a specific, and already widely-used, technique (play) for working with reluctant children. The author illustrated the use of various play techniques but, because of the small subject population, and the absence of controls, the conclusions cannot readily be generalized to the child population as a whole.

Numerous researchers, whose reports were designed primarily to encourage the use of one or another engagement/therapy technique, have referred to the problem only indirectly as a starting point. Representative of these writers are Horovitz (1983), who discussed art therapy, Dunne (1988), who dealt with drama therapy, Adler and Fisher (1984), who addressed music therapy, and Johnson (1984,1987), who applied computer technology to existing art and drama techniques.

Causes of the problem behavior, as reported in the literature, typically accentuate the individual psychology of the child, and reflect the wide range of theoretical frameworks which exist in the field. Samples of these wide-ranging approaches, leading in the final analysis to highly inconclusive results, include Buxbaum (1981), who suggested that children who refuse to engage with a psychologist may be in a continuous temper tantrum, McCarthy (1989), who saw the behavior as a replication of the child's method of dealing with upsetting issues at home, and Deering (1986), who suggested that the reluctant child is afraid of revealing sexual and aggressive drives. Horovitz (1983) presented a list of broad and poorly delimited possible causes, but one element, the inability to trust adults, underscores a common theme.

Taken as a whole, this review of the limited literature dealing specifically with the counseling/therapy setting, suggests that, while widely recognized as a problem, the question of a child's reluctance to participate actively in counseling and related assessment activities has scarcely been addressed directly through research. Most related studies appear to accept the problem as a given factor, then discuss a wide variety of presumed but unproven causes, and move on quickly to the discussion of a particular intervention technique, none of which, in their broad outline, is new. If a pattern of possible causes for the problem can be extracted from the literature, it would seem to center, first, on the issue of the child's lack of and/or loss of control over the situation, and, second, on a general lack of appeal to be found in the counseling encounter. The writer therefore thought that it was possible that an engagement technique involving enhancement of the child's sense of control, along with an increase in the level of appeal and interest, might prove useful in facilitating interaction with resistant children.

The problem, as seen within the classroom setting, where it is more likely to be referred to as "withdrawn behavior" or "shyness," has been treated in much the same way: its existence is a fact of life which few have bothered to study directly. Typical is this opening

statement in an article by Meyer and Berg-Cross (1976): "It seems as though every classroom has a few shy, retiring students who never ask questions and only occasionally answer questions when directly confronted" (p. 332). The specific behaviors described by Meyer and Berg-Cross are much like those seen in the consulting room: general or specific inattentiveness, low and infrequent vocalization, inability to provide information, reluctance to seek information, deficiency in the conventional forms of interaction, and difficulty both in expressing feelings and in responding to the expressed feelings of others.

Chenfeld (1989) opined that, while those withdrawn children who are also perceived as "disturbed" are referred to counselors or psychologists, most withdrawn children remain in the classroom without additional services, and are frequently dismissed simply as "indifferent" or "non-participating (p. 25).

One specific, and diagnosable, manifestation of withdrawn behavior is elective mutism. The *Diagnostic and Statistical Manual [DSM-IIIR]* (1987) describes the disorder as refusal to speak in one or more social situations, particularly in school, even though the ability to communicate verbally is present (p. 88). Kolvin and Fundudis (1981) reported that for every 1,000 children, there may be 7.2 at age five years who do not speak in

school. The electively mute child, however, will frequently communicate through a variety of nonverbal means (*DSM-IIIR*, 1987), and thus does not always present as a truly non-participating or unengaged child.

Honig (1987), in her extensive review of the literature, described avoidance of gaze, unwillingness to accept friendly social overtures, and feelings of discomfort with strange persons as the familiar elements of the child who resists becoming engaged. Pollard (1984), as cited in Honig, indicated that shyness is elicited in unfamiliar situations and by people who are seen as different, powerful, or evaluative. These conditions perfectly describe both the classroom (for the young child) and the consulting room.

The general conclusion from the literature reviewed is that the problem is wide spread, that the causes within the child may be too numerous and/or varied to pinpoint, and that focusing on situational changes in the adult-child encounter, rather than on the individual psychological makeup of the child, may be a productive approach to the problem. Causes extracted from the actual encounter situation appear to cluster around perceived threat from the adult and lack of interest in what is taking place.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

The overall goal of the practicum was to obtain a decrease in the incidence of children in grades K through 2 who received diminished counseling and/or non-psychometric evaluation services, or who would have been dropped from the caseload prematurely because they could not be successfully engaged in the evaluation or counseling process. It was hoped that, at the end of the three month period, a solution would be found which might supplement or replace existing, commonly used strategies. Because the problem seen in the consulting room is quite similar to that seen in the school counselor's office, and, to some extent, in the classroom, it was hoped that a successful solution to the problem might find application in the school setting as well.

Behavioral Objectives

The following behavioral objectives were projected for this practicum:

Objective 1: At some point during the three month implementation period, all children participating in the

project would begin to demonstrate adequately engaged behavior, either verbal or nonverbal, with the writer.

Objective 2: At some point during the three month implementation period, all children participating in the project would successfully complete a non-psychometric psychological evaluation.

Objective 3: At no point during the three month implementation period, would a child need to have services terminated prematurely due to failure of the writer to engage the child in the evaluation/counseling process.

Objective 4: At the end of the three month implementation period, adequately engaged behavior would be maintained without continued application of the solution strategy.

Measurement of Objectives

Objective 1 was measured using a time sampling technique. Each session with the child was divided into six, five-minute sections for the purpose of record keeping. If participatory behavior occurred during a five-minute segment, a score of 1 was given; if no participatory behavior occurred, a score of 0 was given. Participatory behavior was considered "adequate" when a child received a minimum score of 3 per session. For the purposes of this practicum, the disengaged child was described as one who

gave no verbal response beyond "yes" and "no" (or appropriate head movement), who would not participate in art activities, who would not participate in story-telling activities, and who would not play, alone or with the writer, other than to repeatedly handle an object in a non-purposeful manner. Participatory behavior, then, was defined as any behavior which did not characterize the disengaged child.

Objective 2 was measured by the successful completion of two of the following: one directed drawing task; one structured story-telling task; one interactive play task. The directed drawing task involved completion of either a human figure drawing or a kinetic family drawing. Examples of structured story-telling tasks used are the *Children's Apperception Test* (Bellak and Bellak, 1980), the *Children's Apperception Test (Human Figures)* (Bellak and Bellak, 1975), and the *Roberts Apperception Test for Children* (Roberts, 1982).

Objective 3 was a simple tally of children not recommended for premature discharge due to failure of the writer to engage the child in the evaluation/counseling process.

Objective 4 was a simple tally of those children who continued to demonstrate adequate participatory behavior, as

defined for Objective 1, for three sessions following termination of the solution strategy.

Mechanism for Recording Unexpected Events

A log was kept summarizing each session for each child participating in the project. Unexpected events which might have a bearing on the outcome of the practicum were included in this log. Except for the initial recruitment of children, there were no significant events which might have affected the outcome of the practicum.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Possible Solutions

The problem addressed by this practicum was that, (A) because some children cannot or will not interact adequately with the professional, either verbally or nonverbally, assessment and/or counseling services are often terminated prematurely, and (B) if services are indeed continued with such children, they are often provided within a distinctly suboptimal context. The focus of the practicum was on developing a technique for engaging the reluctant child; it did not address the question of therapeutic technique.

The psychology/counseling literature which addresses the problem from within the narrowly defined context of the practicum, as opposed to dealing with therapeutic intervention, has already been shown to be extremely limited. Indeed, it was necessary to extrapolate conclusions from studies which dealt primarily with therapy issues. Horovitz (1983), for example, reported on a project involving the use of art therapy with three preschool children who were emotionally deprived and distrustful of adults. Therapeutic gains were seen in all three children, as measured by gains in their cognitive skills. While the study did not deal specifically with the question of

engaging children who are difficult to engage, the implied conclusion is that art therapy, once having been shown to be therapeutically effective, may reasonably be assumed to have been effective in overcoming as well the reluctance in the children studied.

In the same way, Dunne (1988) reported on the use of drama therapy with conduct disordered, autistic, and schizophrenic children, all of whom would generally be considered difficult to engage. Since therapeutic gains were reported, the results may be seen as an implied proposal that drama techniques can be useful in engaging the reluctant child. A similar pattern is seen with recommendations for the use of music therapy (Steele, 1984), play therapy (Bow, 1988), multi-art therapy, involving music, movement, and art (Adler, R.F., and Fisher, P., 1984), and the application of computer technology to both art and drama therapies (Johnson, 1984 and 1987).

In an interesting study which compared two different approaches to therapy, and involving 49 children (all inpatients, mean age 7.75 years), one group was treated using music therapy and a second group was treated using play therapy (Froehlich, 1984). Findings suggested that a more involved type of verbalization was elicited by the music therapy than by the play therapy.

Within the past decade, video technology has been brought to the consulting room, but, again, the focus has been on use of this technology as an instrument of therapy. Thus, intervention involving videotaping has been primarily of two types: (1) presentation of cognitive information to therapy clients by means of taped material (Tinsley, 1988), and (2) use of playback to allow clients to see and discuss their own behaviors (Webster-Straton, Kolpacoff, and Hollinsworth, 1988; Cooker and Nero, 1987; Corder, 1981).

In an early study (Annis and Perry, 1978), videotape techniques were found useful, through modeling behavior, in helping clients to disclose information about themselves and their feelings. Somewhat more creative use has been made of video technology by Stirtzinger and Robson (1985). In their project, a group of eleven- and twelve-year-old girls were encouraged to write, produce, and perform their own plays, which were then videotaped and played back for group discussion. The writers found that, not only were certain psychotherapeutic gains made, but resistance to the formation of group cohesiveness was largely overcome.

The education-based literature which addresses the problems of working with the withdrawn child seems dominated by common sense generalities which, while not seeming incorrect, nevertheless do not present a comprehensive analysis of a specific technique. The general trend of

recommendations found in these studies is for the adult to be tolerant and patient, and to routinely include the withdrawn child in activities even though he/she does not appear to be actively participating (Chenfeld, 1989; Honig, 1987; Meyer and Berg-Cross, 1976).

Description and Justification for Solution Selected

The writer decided to make use of video technology in attempting to solve the practicum problem. There were four major reasons for the selection of this particular solution.

1. Traditional approaches involving art, play, music, or drama have been available for decades. They have been widely used and widely researched. Video technology, on the other hand, is relatively new; the possibilities for application have by no means been exhausted.

2. Traditional approaches are closely tied to the therapeutic theories which drive them. Little attention appears to have been paid to their direct ability to facilitate the participatory behavior of reluctant or resistant children.

3. The writer's professional experience, and those of the professionals with whom he has consulted, indicated that the traditional techniques were not effective all of the time with all of the children. Development of an additional and/or supplemental approach would therefore expand the

repertoire of techniques available to adults working with children.

4. The use of video technology directly addresses the four specific factors which the writer had identified as probable causes of the problem: inadequate child-based control of the situation, lack of novelty, history of failure at certain activities, and lack of opportunity to monitor one's own behavior in a new and possibly threatening situation.

The selected solution could be readily implemented in the writer's work setting: the writer had discretion to initiate such a project without the approval of a supervisor; physical facilities were adequate for carrying out the project; children could be located to participate in the study; technical equipment was largely available. It was necessary to purchase a new, full-featured VCR tape player with remote control.

Report of Action Taken

The solution strategy for this practicum began in February, 1991, after approval to begin implementation had been received. Since the clinic's caseload did not at that time include an adequate number of significantly reluctant

children to participate in the program, contact was immediately made with elementary guidance counselors in two local school districts. Three counselors were able and eager to refer a total of four youngsters. Two of the children were enrolled in kindergarten, one boy and one girl, both six years of age. Two of the children were enrolled in first grade, one boy and one girl, both seven years of age. Since the beginning of the current school year, all four children had refused to speak in school, either to teachers or to other children. Moreover, the guidance counselors had been unable to engage these children in counseling activities using traditional interview, art, play, and story-telling approaches.

The writer contacted each parent by telephone; all parents were enthusiastic about having their children participate in the program, and intake conferences were scheduled. Recruitment of youngsters, therefore, formed the first step of implementation.

During the second step, individual conferences were held at the clinic with each parent. Each conference lasted approximately one hour. During this time, the writer explained the nature and purposes of the program, and he encouraged parents to ask questions. Parents were also given an opportunity to talk about their child's developmental history, social history, likes and dislikes,

personality, and any special features of the child's life that might be pertinent. Parents were then asked to sign a "Consent to Videotape" form (Appendix A), and were told that a follow-up conference would be held at the end of the program.

During the third step, which lasted for seven weeks, the children were seen individually by the writer in sessions lasting approximately 30 minutes. The 30-minute time period was chosen instead of the traditional 50-minute period because of the children's young age and their history of being very difficult to engage. At the first session, each child was shown into the consulting room. This is a comfortable, carpeted room with a living room atmosphere, containing upholstered furniture, a large work table with upright chairs, many kinds of toys, and drawing materials. The room is arranged so as to allow both close contact and wide separation between the writer and the child, depending on the needs of the situation. The video equipment was set up in plain sight on a desk in the vicinity of the toys and work table.

During this first contact session, an attempt was made to treat each child in essentially the same manner as all new clients. They were introduced to the various features of the room, and encouraged to explore at will. Because these children had all been very difficult to engage,

however, the writer was somewhat more directive with them than is usually the case.

During the second session, each child was again encouraged either to play with the toys or to use the drawing materials. None of the children actually participated in these activities, but once the child was physically in position for these activities, the writer said, "Let's see what's on TV." The video camera and monitor were then turned on to the view-through mode. That is, a live telecast was provided within the room.

During the following five weekly sessions, a variety of techniques was tried, generally following what appeared to be each child's inclinations. The view-through mode was used throughout this period, even though taping was also taking place. Children were encouraged to make faces "for the TV", to clown around, to play "Simon Says" with the writer, to show their drawings, to produce make believe shows using various toys, to explain or tell stories about their own drawings and, eventually, to tell stories about the pictures of the *RATC, CAT, or CAT-H* pictures. The writer had to be sensitive to the direction in which each child seemed to be going, as it was necessary with this type of child to avoid forcing him/her to perform in a certain way. Overall, however, there was a general progression from lack of structure (clowning around), towards specific task

completion (making up stories for projective pictures).

Attempts were made to interest the children in watching the playback of their activities, and in experimenting with special effects such as high speed, reverse, etc. None of the children was interested in viewing the playback; emphasis was thus maintained on the view-through mode throughout these sessions.

During the fourth step, encompassing the three final contact sessions with the children, the video equipment was turned off. The purpose of this was to determine if the participatory habits which were developed during the video phase would be maintained even when the video equipment was not in use. One child insisted on using the video equipment during this three-week phase, and was allowed to do so. (The fact that this heretofore uncommunicative child was able to "insist" on anything was noteworthy.) One child requested the use of the equipment during the last session so that she could produce a special show for her mother, and she was allowed to do this.

The fifth, and final step in the implementation consisted of an individual conference with each parent. The child's progress through the program was described, and sample tape footage was shown in order to illustrate the changes in behavior. Parents' questions were answered, and recommendations were made for ways in which the parents

might encourage continued positive growth. One parent requested that her child remain in ongoing therapy with the writer.

CHAPTER V

RESULTS, CONCLUSIONS, RECOMMENDATIONS, AND DISSEMINATION

Results

The problem which existed in the writer's work setting, and in related settings in elementary schools, was that some children were so difficult, or impossible, to engage in the evaluation and/or counseling processes, that they either had services terminated prematurely or they were provided with ongoing, but distinctly sub-optimal services.

The solution to the problem was to make use of video technology to encourage these highly reluctant children to reach a degree of active participation in the evaluation and counseling processes. The program consisted of an initial conference with parents, ten individual, weekly sessions with each child, and a follow-up conference with parents.

The overall goal of the practicum was to obtain a decrease in the incidence of primary school children who were dropped from the counseling caseload prematurely, or who received markedly diminished evaluation and counseling services, because they could not be successfully engaged in these processes. It was hoped, therefore, that the solution would provide a new strategy to supplement or replace the existing, commonly used strategies. It was further hoped that a solution that was found to be effective in the

writer's clinical setting, might also find application in the school counselor's office.

Specific objectives were designed to achieve these goals. The following is a list of each objective along with the results related to that objective.

Objective 1: It was projected that, at some point during the three month implementation period, all children participating in the project would begin to demonstrate adequate participatory behavior, either verbal or nonverbal, with the writer. Participatory behavior was defined as any of the following: giving verbal responses beyond "yes" and "no" (or head nodding); playing alone or with the writer, beyond merely handling an object in a non-purposeful manner; participating in art activities; participating in story-telling activities. For this participatory behavior to be considered adequate, it was necessary for it to be displayed during three or more five-minute sectors of each contact session, and to occur during three out of four consecutive sessions. A child was given a score of 1 for each five-minute sector during which the desired behavior was displayed. All children met this objective. Figures 1 through 4 summarize the scores for each child, while Figure 5 presents the mean scores for all four children.

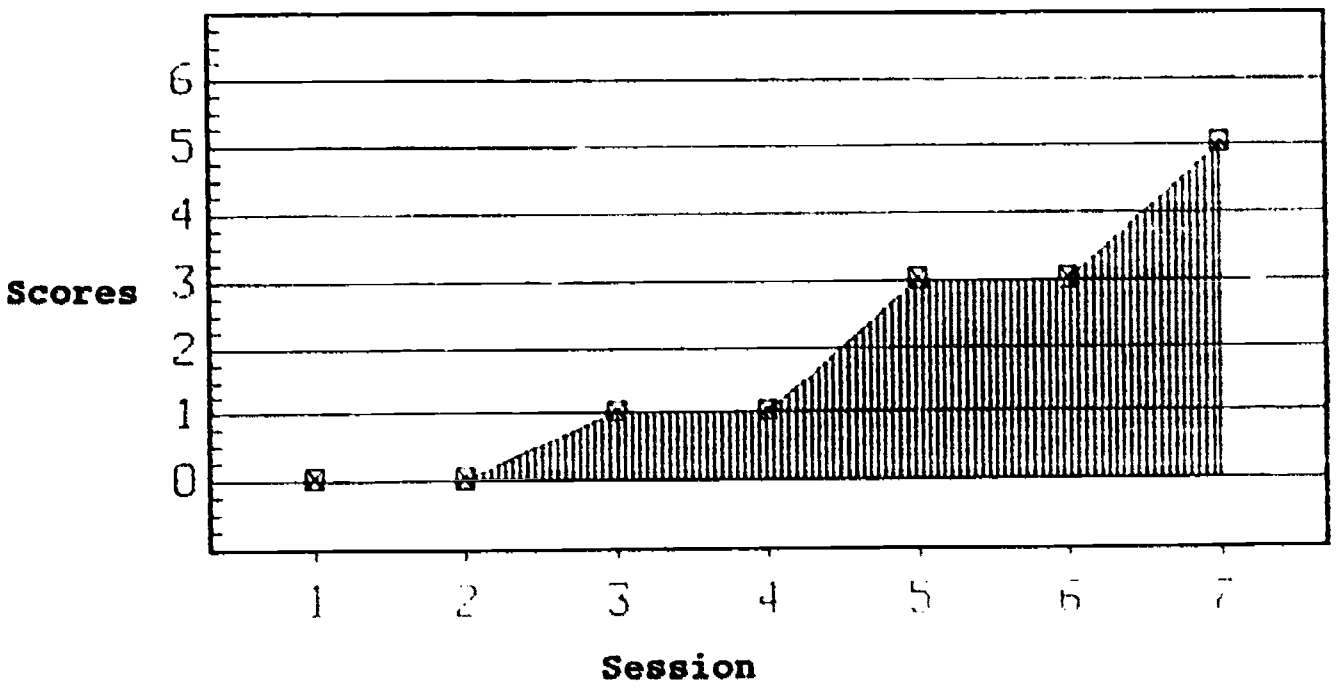

Figure 1. Active participation scores by session (Fred)

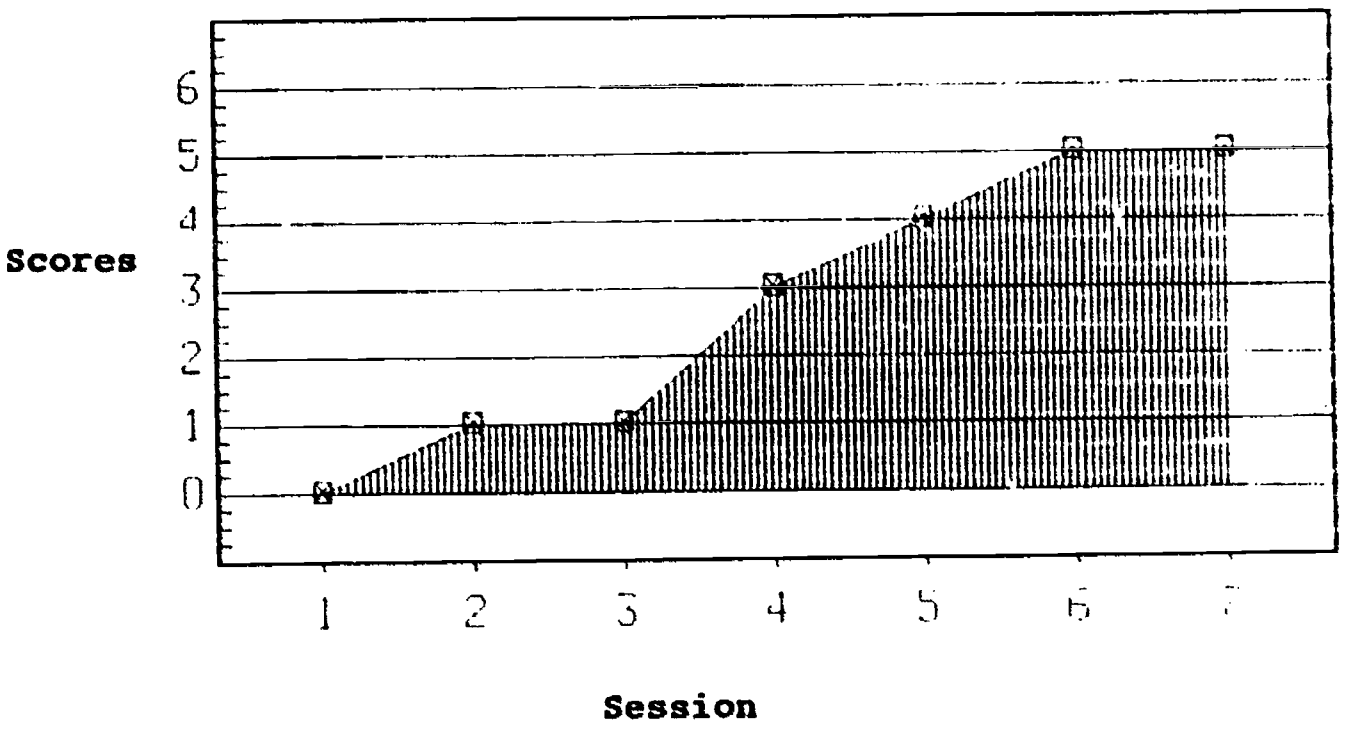

Figure 2. Active participation scores by session (Jared)

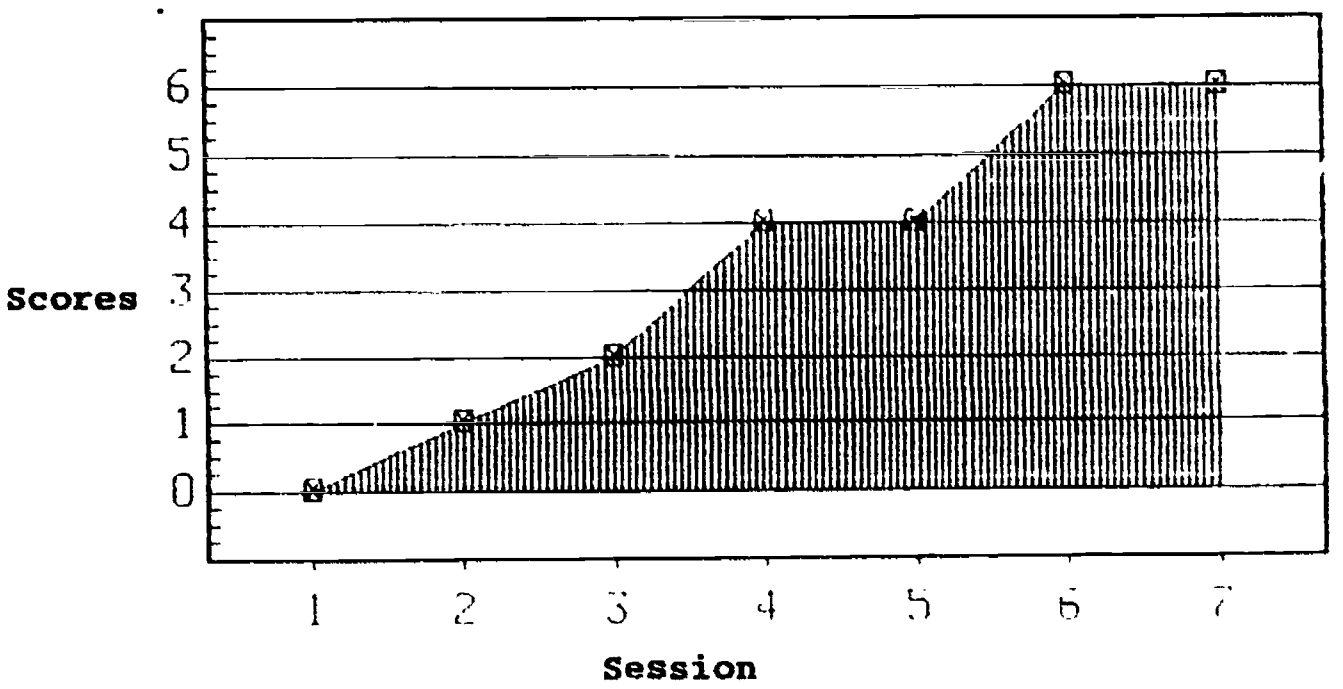

Figure 3. Active participation scores by session (Nadine)

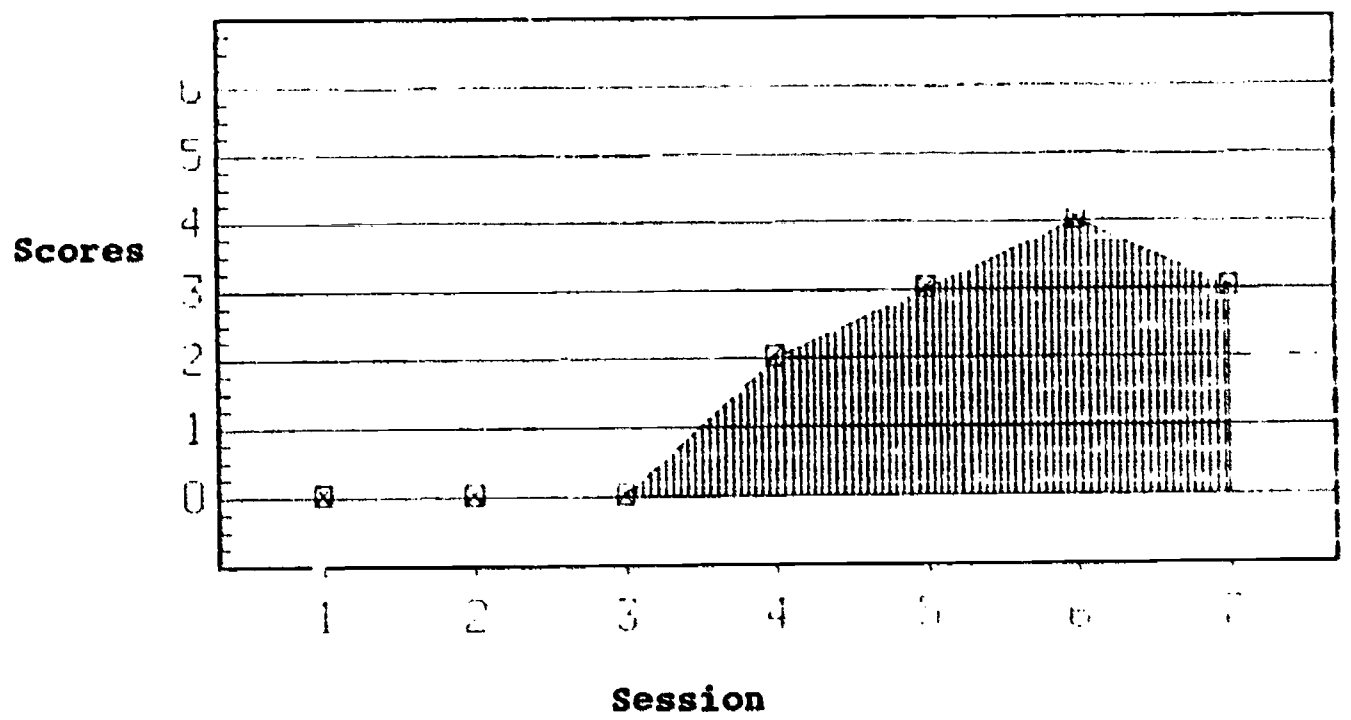

Figure 4. Active participation scores by session (Tina)

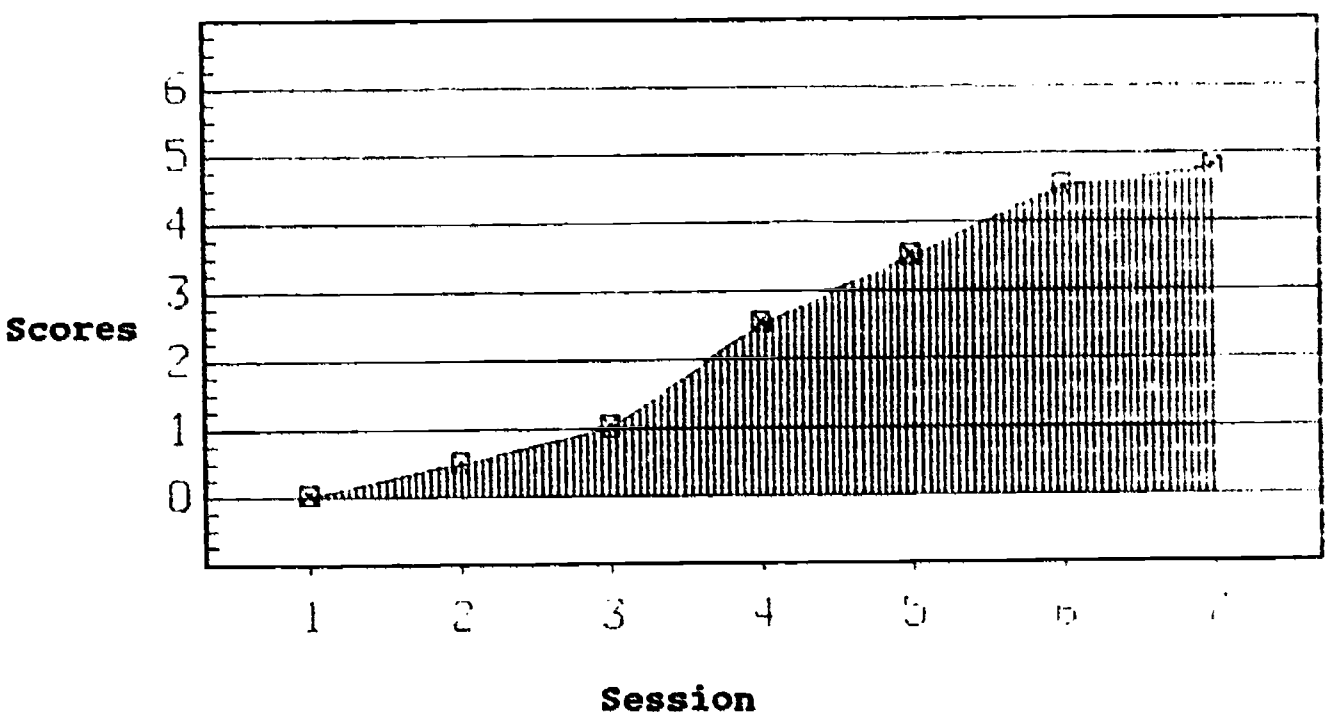

Figure 5. Active participation scores by session (means)

Because failure to speak in school was a common, specific problem for all of the children participating in the practicum, Tables 1 through 3 are included to summarize changes in that particular behavior during the course of the program.

Table 1.

Incidence of Children Speaking to the Television

Child	Session 1	2	3	4	5	6	7	8-10
Fred	No	No	No	No	Yes	Yes	Yes	N/A
Jared	No	No	No	Yes	Yes	Yes	Yes	Yes
Nadine	No	No	No	Yes	Yes	Yes	Yes	N/A
Tina	No	No	No	No	No	No	No	N/A

Table 2.

Incidence of Children Speaking to the Writer

Child	Session 1	2	3	4	5	6	7	8-10
Fred	No	No	No	No	No	No	Yes	Yes
Jared	No	No	No	No	No	Yes	Yes	Yes
Nadine	No	No	No	No	Yes	Yes	Yes	Yes
Tina	No	No	No	No	No	No	No	No

Objective 2. It was hoped that, at some point during the three month implementation period, all children participating in the project would successfully complete a non-psychometric psychological evaluation. All children did indeed complete the required two out of three non-psychometric tasks, as summarized in Table 3.

Table 3. Number of Children Completing Non-Psychometric Evaluation Tasks

Task	Number of Children Completing (n=4)
Structured Drawing	4
Projective Story Telling	3
Interactive Play Activity	4

Objective 3. It was anticipated that, at no point during the three month implementation period, would a child need to have services terminated prematurely due to inability of the writer to engage the child in the evaluation/counseling process. All children attended all scheduled sessions. All children made sufficient progress to warrant receiving continued services.

Objective 4. It was hoped that, at the end of the application period, adequate participatory behavior would be maintained without continued application of the solution strategy. Figures 6 through 10 present this data and relate it to the behaviors shown during the application period.

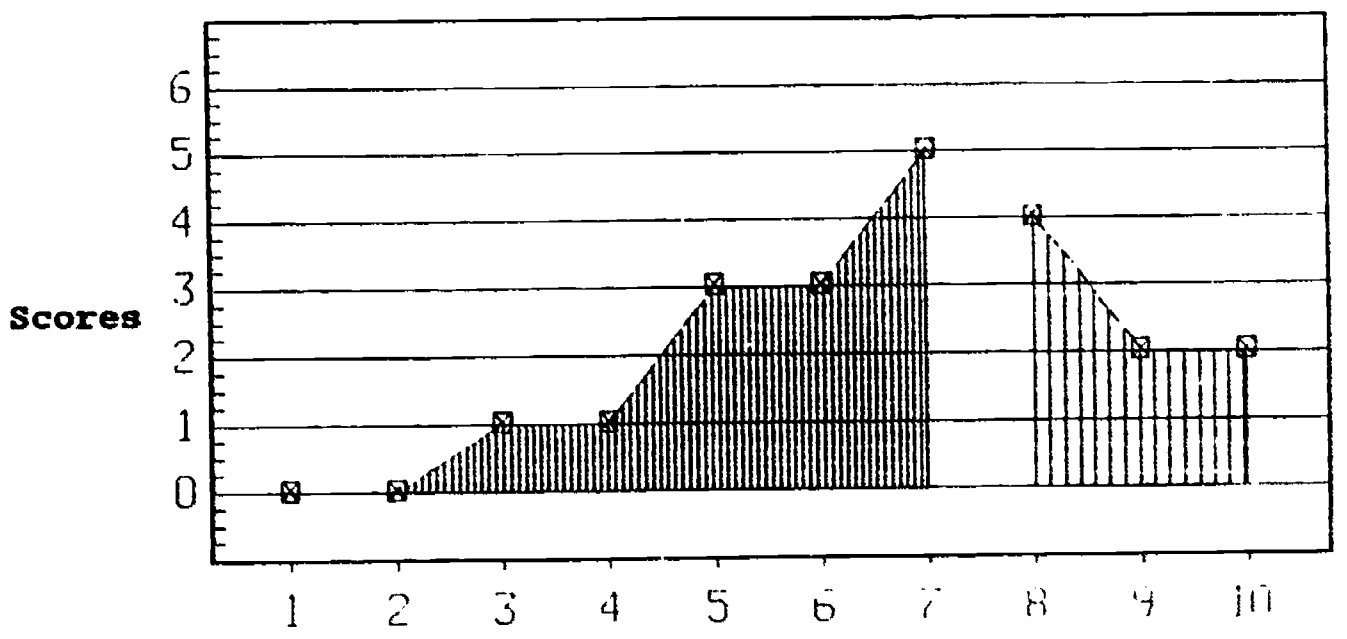

Figure 6. Active participation scores during and after application of the solution strategy (Fred)

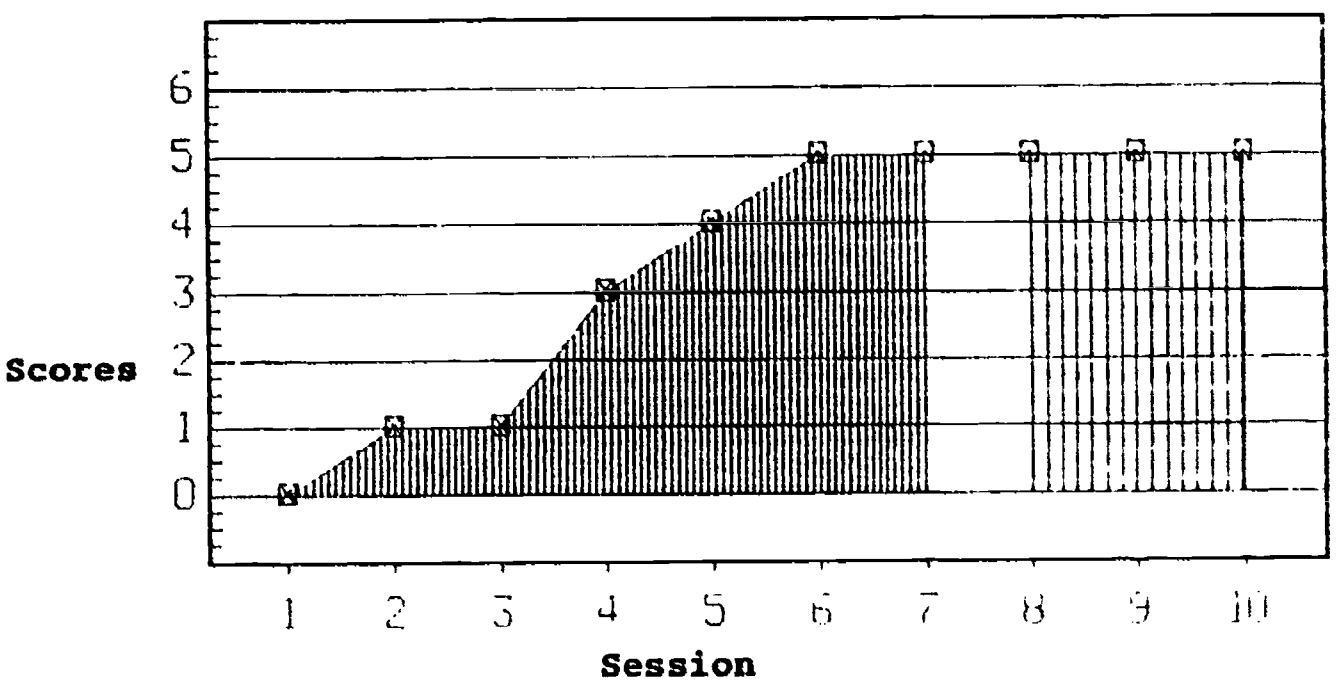

Figure 7. Active participation during and after application of the solution strategy (Jared)

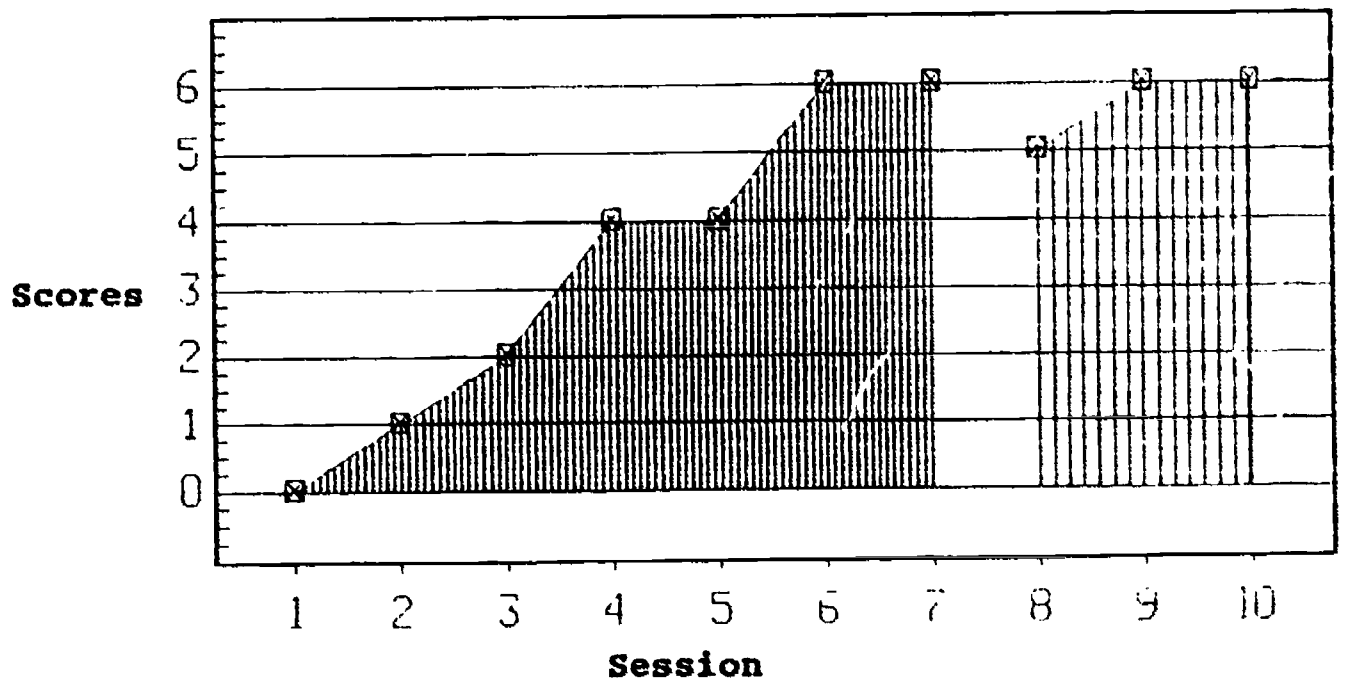

Figure 8. Active participation during and after application of the solution strategy (Nadine)

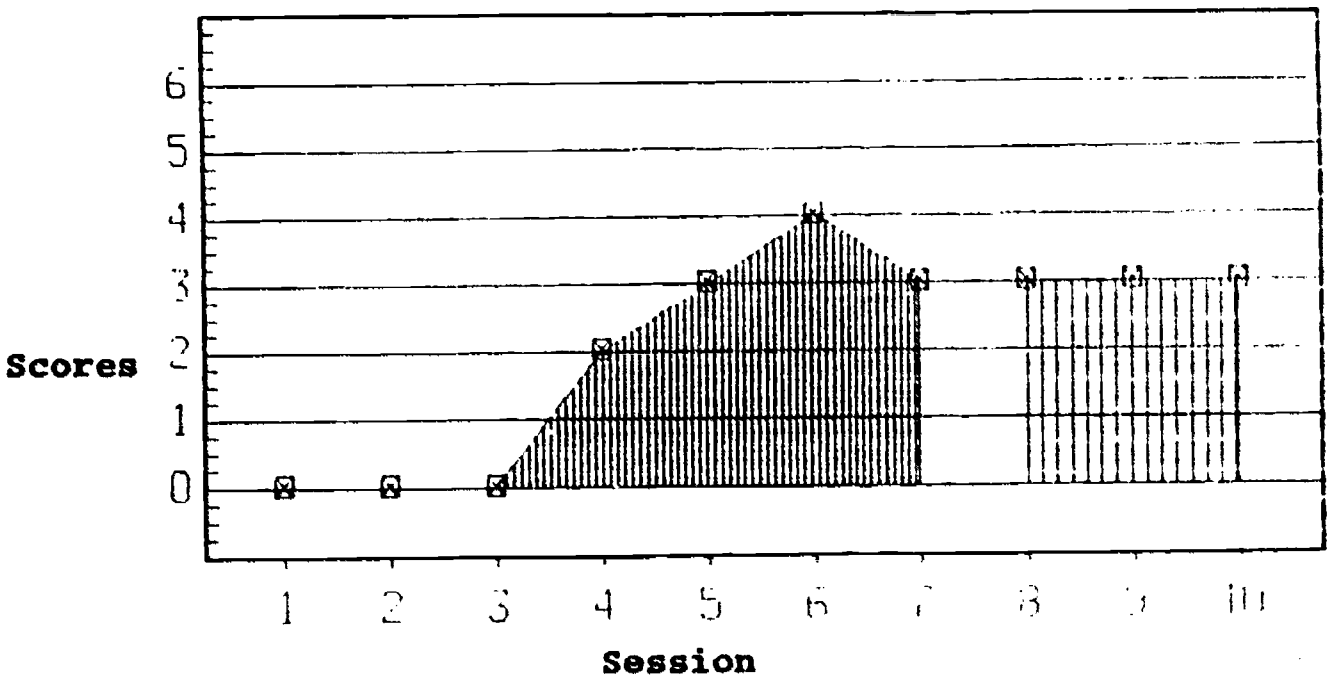

Figure 9. Active participation during and after application of the solution strategy (Tina)

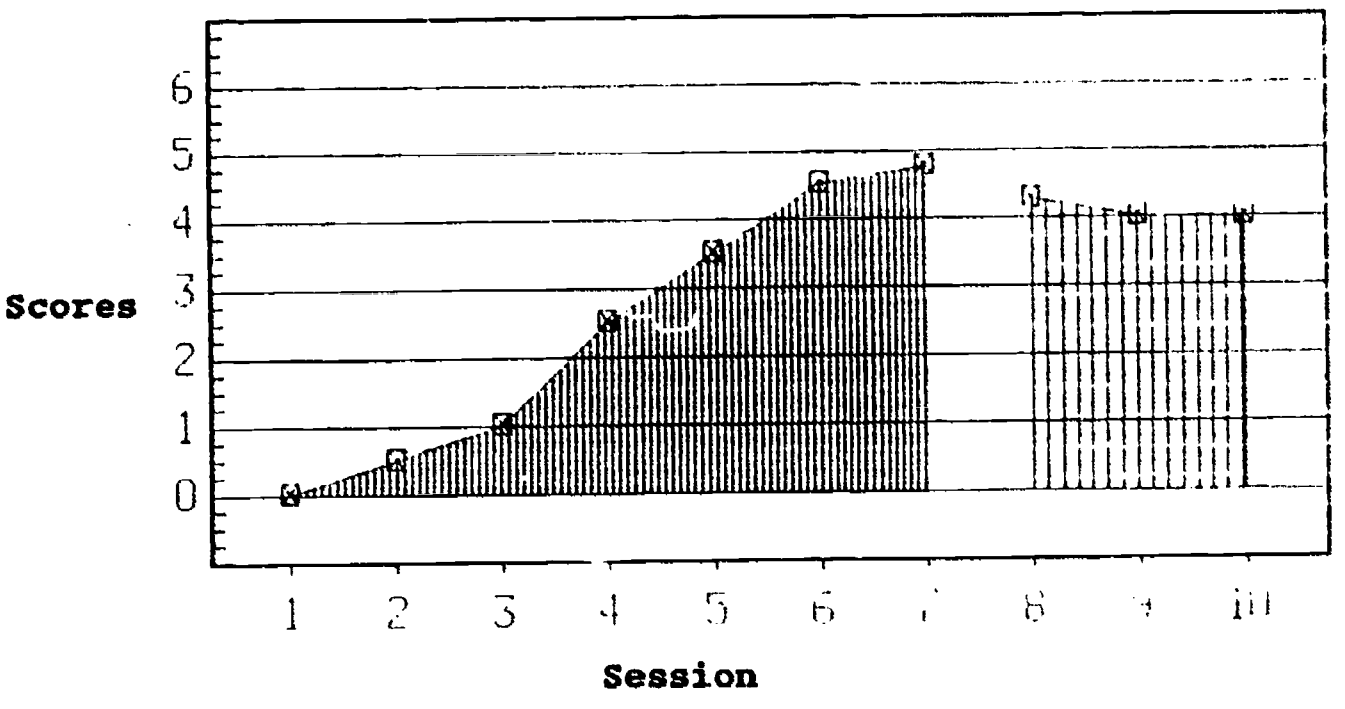

Figure 10. Active participation during and after application of the solution strategy (means)

Since failure to speak in school was a specific common problem for all of these children, follow-up data on changes in that behavior are summarized in Table 4.

Table 4. Children Who Spoke in School

Child	Start of Program	End of Program
Fred	No	No
Jared	No	Yes
Nadine	No	Yes
Tina	No	No

Anecdotal Summary. Because of the particular nature of this practicum, there are several features of the project which are not immediately discernable in the data presented above. Much of the essence of the tone and effectiveness of the solution strategy can be seen in the story of Jared. While not identical in every detail to the behaviors of the other children, Jared's pattern is seen as typical in its broad outlines.

Jared was six years old and a kindergarten student. When he came to the clinic in February, he had not yet

uttered a single word in school. Interaction with the other children was minimal, as was participation in classroom and playground activities. The guidance counselor, an experienced and talented professional, had been unable to elicit participatory behavior in her individual and group sessions with him. Thus, Jared had had to be placed on "monitor only" status.

At the clinic, Jared had to be led by the hand into the consulting room. During the first session, he found a place on the floor to stand, and he remained rooted to that spot for the full 30 minutes. During the second session, Jared was placed at the work table, given the drawing materials and encouraged to draw or write. It was possible to coax him to hold a marker, and he eventually dabbled listlessly and uncertainly on the paper. When the writer turned on the TV and Jared saw himself on the screen, the reaction was a mixture of surprise and delight, although there was no immediate change in interactive behavior.

During the following sessions, Jared began to play to the TV, beginning a pattern of interaction with the TV, rather than with the writer, which was perhaps the most notable feature of the children's behavior during this program. Jared became bolder and bolder, playing all sorts of "games" with his own image on the TV. Eventually, it was possible to engage him in a game of "Simon Says;" again, the

focus of Jared's interaction was the TV, not the writer. As it turned out, Jared had quite an interest in drawing, and he was able, with some direction, to draw specific pictures requested by the writer. With some encouragement, Jared showed his picture to the TV, positioning himself carefully so that the picture occupied the full screen. This provided another opening for him, and he began, spontaneously, to draw pictures of his own choosing, and to show them to the TV. With time, Jared was able to show a picture to the TV and also to tell about the picture. This was a major breakthrough, which led to the successful completion of a projective story-telling task. Since Jared was apparently not yet able to tell the stories to the writer, he was encouraged to hold up the stimulus cards to the TV and to tell the stories to the TV.

Eventually, Jared was able to interact verbally with the writer, although this was unpredictable and never extended throughout an entire 30 minute session. Through communication with Jared's mother and guidance counselor, it was learned, towards the very end of the project period, that Jared was beginning to talk to the teacher and the classroom aide in a one-on-one situation.

Discussion

A review of the results of this project indicates that all four objectives were met to one degree or another. It was clear that all of the children whose active participation could not previously be obtained were now able to become sufficiently involved in the process to complete two non-psychometric evaluative tasks, and that the ability to interact extended for a period after termination of the solution strategy.

The most notable feature of the children's behavior was their ability to begin interaction with the TV considerably earlier than they were able to interact directly with the writer. None of these young children showed interest in seeing tapes of themselves, or in playing with special effects. It was almost as if the images of themselves on the TV screen provided a neutral third person in the room, part themselves and part another. Whereas all children found it initially impossible to draw a requested picture and tell about it directly to the writer, three of the four were able to tell about the picture when facing the TV. Indeed, in many cases, this process emboldened the children sufficiently to cause them to become a bit experimental with the procedure. Even the fourth child, who never spoke at any time, was nevertheless able to proceed through all of the TV-related activities without speaking.

With particular regard to speaking, it should be remembered that verbal interaction was not a specific objective of this practicum. While all but one of the children did eventually speak during the course of the project, it is important to note that at no time did any of the children speak with the openness and fluency typical of children their age.

The overall conclusion from this practicum is that the use of VCR technology, specifically the use of the view-through mode, is an effective means of increasing the degree of participatory behavior in children who have been extremely difficult or impossible to engage. This was seen to be effective in the consulting room of a private psychological clinic, and there is every reason to believe that a similar degree of effectiveness would be seen in individual sessions with the school guidance counselor. Because of the setting in which the practicum was conducted, it remains questionable if the solution strategy would be applicable to the classroom situation.

Recommendations

1. Because two of the children in the project began to show progress only towards the end of the practicum period, it is recommended that further use of the technique be

extended beyond the seven weeks required by the constraints of the present project.

2. In response to queries from school guidance counselors, it is recommended that attempts be made to apply the solution strategy to small groups of children. This would be helpful to counselors with their large caseloads, and might also serve to facilitate interaction among children.

3. It is also recommended that attempts be made to make use of the solution strategy in the primary grade classroom following application in the small group setting.

Dissemination

Results of this practicum, and a summary of ways to implement the solution strategy, have already been shared with the guidance counselors who referred children to the project.

The writer plans to write an article on the technique for submission to a non-research based publication for elementary school counselors.

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APPENDIX A

SAMPLE FORM: CONSENT TO VIDEOTAPE

CONSENT TO VIDEOTAPE

I am the parent or guardian of _____,
a child who is a client of the [ ] Clinic. I understand that the Clinic desires to videotape psychotherapy and or evaluation sessions with my child for use by Daniel J. Russo, psychologist. The videotape(s) will be used to monitor the progress of the therapy and/or to help my child learn to monitor his/her own behaviors more effectively.

The videotape(s) will be maintained in strict accordance with the laws of confidentiality, which require that such information not be provided to any outside individual or agency without written permission of the client or, in the case of a minor child, without written permission of the parent or guardian. Accordingly, the videotape(s) will remain the exclusive property of the clinic, will not become part of the permanent file of the child, and will be destroyed after use.

I give my permission to the [ ] Clinic to utilize videotaping. My consent shall begin on _____, and end on _____.
I understand that my consent may be withdrawn in writing at any time.

Date:_____. Signed:_____.